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Caring for your practice so you can care for your patients.

Physician Best Practice Model: Efficient & Cost Effective

Presented by

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You've Got to be Kidding!



- Medicare is cutting payments, AGAIN!
- New patients are decreasing
- My malpractice insurance went up AGAIN!
- Staff expects annual raises
- My rent and triple net expenses keep rising
- My compensation keeps declining!

Case Study Overview

- Multispecialty Physician Group with 6 satellite locations that have taken a deep dive to assess themselves and the way they practice.
- Situation:
 - Flat Revenue
 - Climbing Expenses

Improvement Goals

1. Reduce Costs
2. Increase Revenues
3. Increase Efficiency
4. Improve Patient Satisfaction
5. Improve Staff Satisfaction

Project Phases

- Phase 1

Assess and measure cost structures, service lines, governance and related operations

- Phase 2

Implement **Process Improvements** to achieve efficiency and cost savings

- Results: **Millions \$aved**

US Healthcare Statistics

Not a pretty picture. In fact...

US Healthcare Needs a Facelift

- Nothing less than a redesign of the US Healthcare System will do, says Don M. Berwick, M.D., newly appointed CMS Administrator by President Obama and co-author of the Institute of Medicine's 2002 landmark report
- He cites excessive inefficiencies throughout the work processes of healthcare.

Waste in the US Healthcare System

- “The bad news is that an estimated \$700 billion is wasted annually.”
- “The good news is that we can reduce healthcare costs without adversely affecting the quality of care or access to care.”
 - Robert Kelley, vice president of healthcare analytics at Thomson Reuters

Inefficiency Costs \$

- Paper-based systems accounts for **6%** of annual overspending
- Administrative inefficiency and redundant paperwork accounts for **18%** of healthcare waste
- Billing and administration take up **one-quarter** of the average US hospital budget
- US doctors spend nearly **8 hours per week** on paperwork and employ 1.66 clerical workers per doctor

Efficiency Defined

- “Efficiency is the reduction of waste and thereby, the reduction of the total cost of care should be never-ending; for example, waste of supplies, equipment, space, capital, ideas and human spirit.”
 - *Crossing the Quality Chasm*, Institute of Medicine (IOM) 2002 landmark report

Continuous Change & Process Improvement

Efficiency Principles

Looking at How Staff & Processes Flow

- **Lean** Thinking Principles cite seven waste areas:
 1. Waste of overproduction
 2. Waste of time
 3. Waste of transportation
 4. Waste of processing
 5. Waste of inventory
 6. Waste of motion
 7. Waste of defects

Rule of Thumb:

To identify all waste,
ask “Why” Five Times
and observe the
workflow processes!

Delivery of Care: Redesign

New Efficiency Design Rule

- Waste is continuously decreased
(Old way was to seek cost-reduction)

Results

- Patient satisfaction
- Revenue Opportunities

Continuous Change & Process Improvement

DNA's Efficiency Approach

- Eliminate non-value added work to achieve better patient, provider & staff satisfaction while increasing revenue opportunities
- Typical findings:
 - Minimum 40-50% work-process steps do NOT improve outcomes and are unnecessary

Continuous Change & Process Improvement

DNA's Efficiency Approach

- When asked “Why?”
 - We’ve always done it this way
 - That’s how I was trained
 - I don’t know
 - “What if” scenarios

Continuous Change & Process Improvement

Case Study: Physician Best Practice Model

Phase 1

- Assess & Measure
 - Cost Structures
 - Service Lines
 - Governance
 - Related Operations

Continuous Change & Process Improvement

Physician Best Practice Model Phase 2

- Implement Improvement Strategies

Time period: 12/31/08 to 12/31/09

- \$3,896,846 in overall expense savings
- \$1,163,809 in salary & benefits savings (30%!)
- \$3,507,000 or 90% ROI (Expense savings minus consultant fees of 10%)

Physician Best Practice Model

How Did We Do It?

New Management Structure

- “Start at the TOP”
- Eliminate Turf Wars
(physicians & non-physicians)

New Physician Leaders New CEO

- Team-oriented
- Open to process changes
- Motivated to reduce expenses
- Proactive vs. Conflict Avoiders

Physician Best Practice Model

How Were Savings Achieved?

Benchmarked to MGMA* Physician Cost Survey/MD FTE linked to productivity, internal variation of satellite locations

- FTEs: MAs, LPNs, RNs, front office, medical records, billing, couriers, accounting finance and lab departments
- Medical supplies & vendors
- Space Utilization

About: Benchmarking to MGMA Revenue/Cost Data

- Remember: sample size may be small or practices dissimilar to the one in review. MGMA values provide a reference point only.
- MGMA benchmarks are indicators of where to best focus improvement efforts.
- The largest disparities indicate the largest improvement opportunities for work redesign.

Benchmarking to MGMA*

Revenue/Cost Data

- Helpful Data Elements:
 - Gross charges/physician
 - Ambulatory encounters
 - Hospital encounters
 - Charge/cost per visit/physician
 - Charge/cost per infusion
 - Charge/cost per lab encounter
 - Charge/cost per imaging encounter

Benchmarking to MGMA Revenue/Cost Data

- Helpful Cost elements:
 - Total operating costs
 - Staff FTE per MD FTE
 - Staff & benefits costs per MD FTE
 - Square footage per MD FTE
 - Medical supplies per MD FTE
 - Variations by locations, if more than one

Benchmarking to MGMA Cost Data

Internal Variation between Service Sites

Staff FTE and Expense by Location					
Location	Staff	FTE	Cost	FTE per MD FTE	Cost per MD FTE
Location A	MD	1.23	-	-	-
	RN	1.80	\$149,115	1.46	\$121,232
	Total Clinical	6.80	\$400,133	5.53	\$325,312
	Reception	1.00	\$37,648	0.81	\$30,608
	Med Records	1.10	\$35,750	0.89	\$29,065
Location B	MD	1.23	-	-	-
	RN	1.80	\$151,830	1.46	\$123,439
	Total Clinical	4.00	\$233,402	3.25	\$189,758
	Reception	2.00	\$82,576	1.63	\$67,135
	Med Records	2.30	\$81,073	1.87	\$65,913
Location C	MD	4.33	-	-	-
	RN	4.50	\$373,641	1.93	\$160,361
	Total Clinical	13.90	\$813,483	3.21	\$187,871
	Reception	3.60	\$147,966	0.83	\$34,172
	Med Records	5.20	\$189,244	1.20	\$43,705

Evaluate!

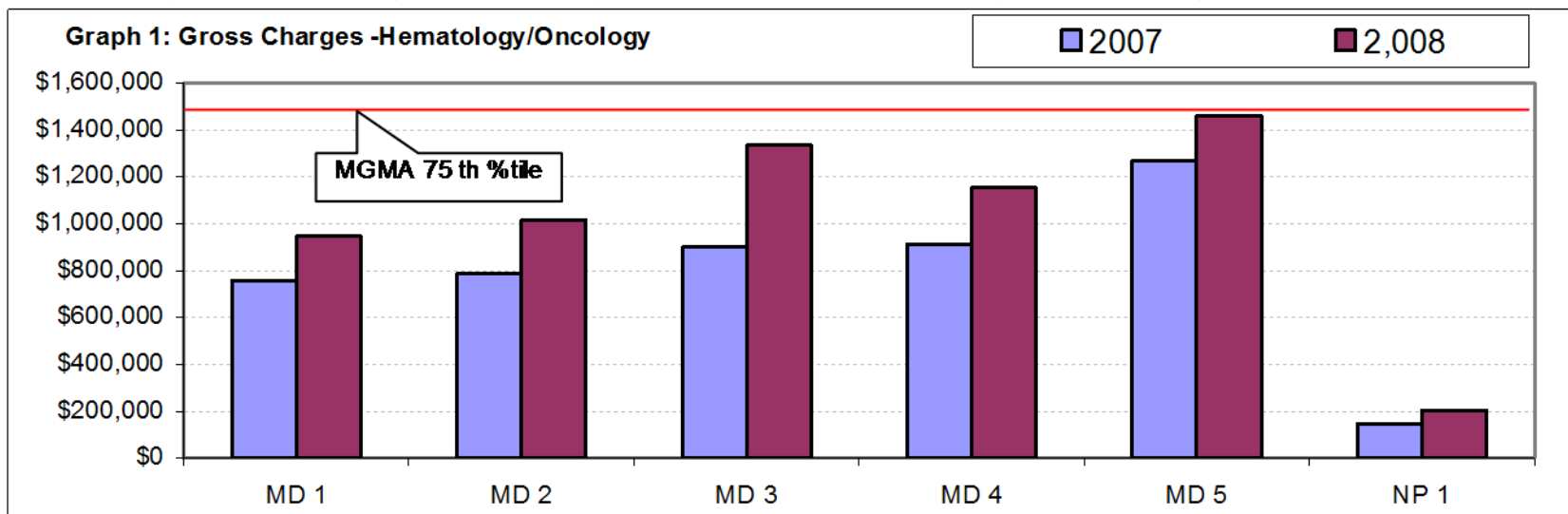
Evaluate!

Conduct Proper Comparisons “Apples to Apples”

Hema/Onc MGMA Median = \$1,086,161

Hema/ Onc MGMA 75th% = \$1,488,955

Gross Charges	2007	% of MGMA Median	% of MGMA 75th %tile	2,008	% of MGMA Median	% of MGMA 75th %tile	% change 2007 - 2008
MD 1	\$757,798	70%	51%	\$945,941	87%	64%	25%
MD 2	\$785,110	72%	53%	\$1,014,663	93%	68%	29%
MD 3	\$901,222	83%	61%	\$1,333,985	123%	90%	48%
MD 4	\$914,327	84%	61%	\$1,151,735	106%	77%	26%
MD 5	\$1,266,350	117%	85%	\$1,460,519	134%	98%	15%
NP 1	\$148,209	14%	10%	\$206,059	19%	14%	39%

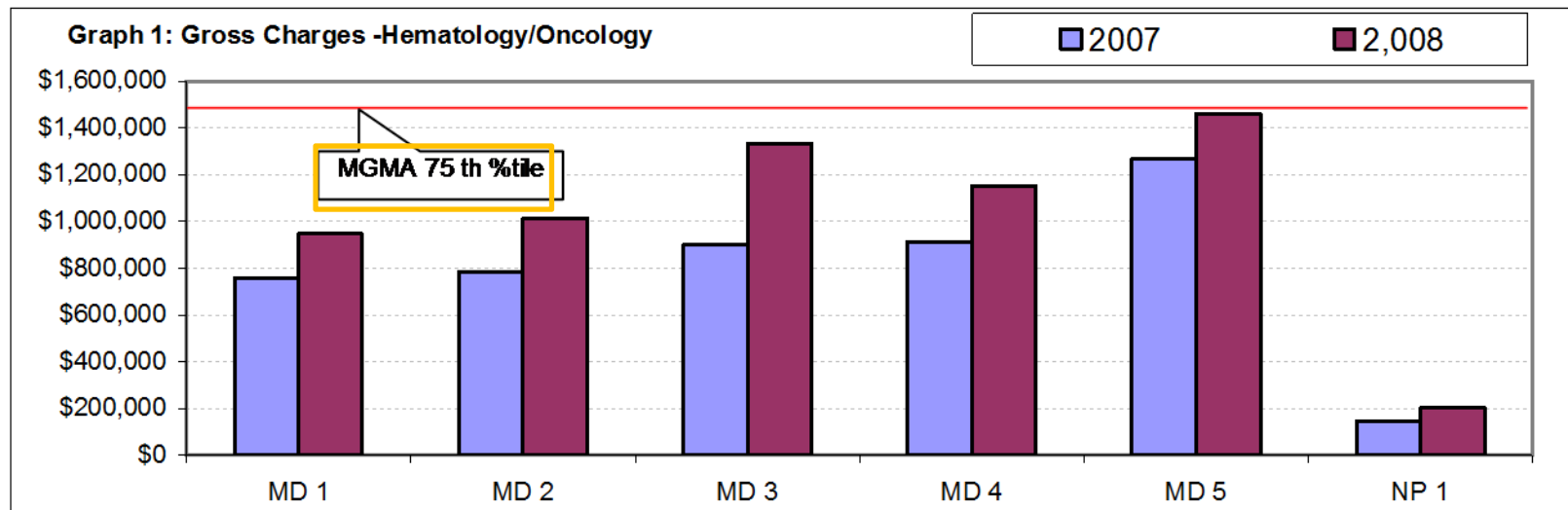


- Ambulatory visits are at 75th percentile
- Gross charges average 80% of MGMA 75th percentile
- Further investigation warranted – check coding & charging procedures

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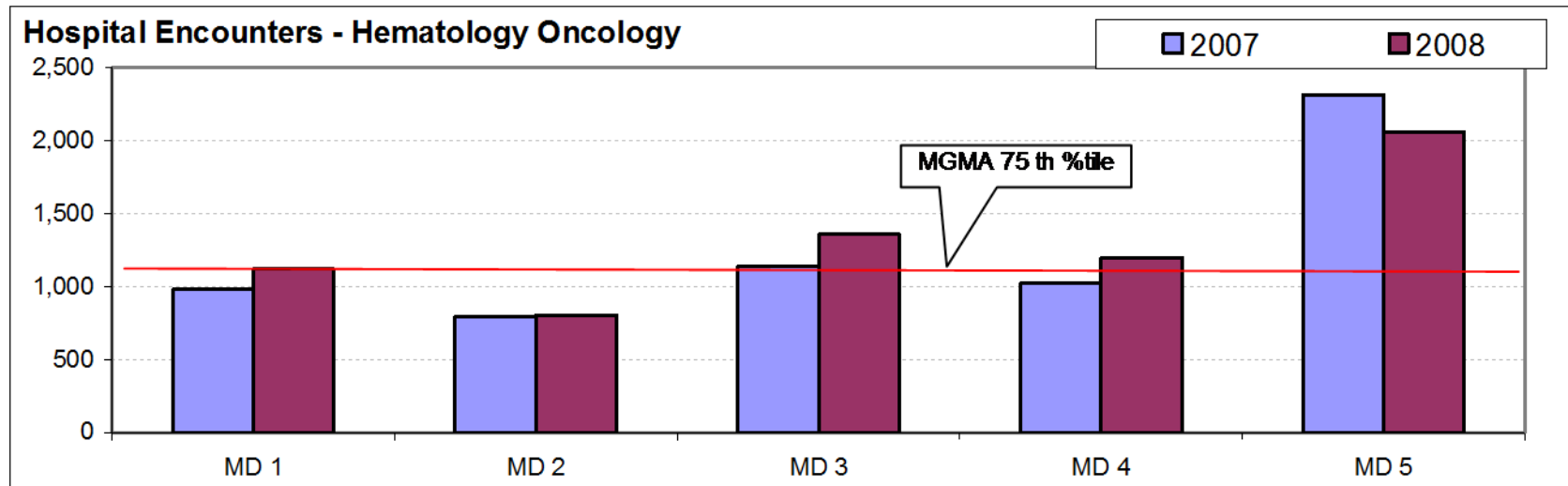


- MGMA Data is for 1.0 FTE, but MD1 (3 productivity slides) is 0.8 FTE
 - Adjust to 1.0 FTE equivalent
- Internal benchmarking: hospital practice sizes (MD2 vs MD5), hospital volume increase except MD5

Hema/Onc MGMA Median = 592

Hema/ Onc MGMA 75th% = 1,040

Hospital Encounters	2007	% of MGMA Median	% of MGMA 75th %tile	2008	% of MGMA Median	% of MGMA 75th %tile	% change 2007 - 2008
MD 1	978	207%	118%	1,117	236%	134%	14%
MD 2	796	134%	77%	806	136%	78%	1%
MD 3	1,139	192%	110%	1,361	230%	131%	19%
MD 4	1,024	173%	98%	1,200	203%	115%	17%
MD 5	2,315	391%	223%	2,062	348%	198%	-11%



Benchmarking MGMA Revenue to Cost Data

Selected Measures

- Operating costs high (all 3 measures), CPCs especially due to low number encounters per MD FTE
- Very high Medical Records FTE per MD & Cost per MD FTE. Recommend work redesign & staff reduction
- Staffing too high if production is at the MGMA Median; preferable at 75th

MGMA Cost Comparisons	Hemat-Onc Practice 2008	MGMA Median	% of MGMA Median	MGMA 75th % tile	% of MGMA 75th
Total Operating cost as % of Revenue	87%	83.00%	105%	85.37%	102%
Total Operating Cost per MD FTE	\$3,860,293	\$3,541,056	109%	\$4,197,336	92%
Total Operating Cost per Encounter	\$1,034	\$622	166%	\$866	119%
Medical Receptionist cost per MD FTE	\$39,440	\$29,737	133%	\$44,042	90%
Medical Records cost per MD FTE	\$45,010	\$11,379	396%	\$16,279	276%
RN Cost per MD FTE	\$140,539	\$112,193	125%	\$141,532	99%
Total Clinical Staff Cost per MD FTE	\$212,797	\$134,332	158%	\$190,608	112%
Medical Receptionist FTE per MD FTE	0.97	1.06	91%	1.53	63%
Medical Records FTE per MD FTE	1.26	0.37	338%	0.56	225%
RN FTE per MD FTE	1.69	1.88	90%	2.55	66%
Total Clinical Staff FTE per MD FTE	3.63	2.50	145%	4.03	90%
RN Staff FTE per 10,000 encounters	3.19	3.52	90%	5.08	63%
Total Clinical Staff per 10,000 encounters	9.72	5.19	187%	6.86	142%
Total Front Office Support per 10,000 Enc.	3.50	4.42	79%	6.85	51%
Total Support Staff Cost per encounter	\$113.08	\$101	112%	\$138	82%

Physician Best Practice Model Implementation: Savings

1. Redesigned management structure / administrative costs
2. Enhanced chair scheduling parameters to maximize staff time (due to RN infusion time study)
3. Just-in-Time inventory for drugs & medical supplies (2 days on hand)
4. Medical Records FTEs & Work Process Redesign
5. Laboratory (FTEs, non-profitable tests, “No Dx, no test”)
6. Imaging (CT): renegotiated maintenance contract & contrast expense, increased internal referrals
7. Leased out excess square footage

Management FTE Reduction

- **\$1.2 million in savings** through restructure
 - Consolidated directors, managers and supervisors
 - Right-sized job positions
 - Right people doing the Right work in the Right time for the Right compensation (market driven)
 - Identified major waste areas of over processing, excessive inventory, waste of motion
 - Identified time wasted

Drug & Medical Supply

1. Assessed current inventory – too much supply on hand
2. Utilization evaluation justified JIT (Just-In-Time) inventory – 2 days on hand
3. **Saved 6% annually** through consolidated ordering with 5 vendors

FTE Reduction & Work Process Improvement

- Determined major tasks through staff interviews
- Observed lack of workflow standardization
- Measured identified non-value added steps

Results:

- Standardized job descriptions, protocols
- Eliminated physical steps through move of charts to check-in
- Implemented scheduled vs instant chart delivery
- Reduced FTEs to align with MGMA cost data

Laboratory Profitability Improvement

- Observed staff & workflow in primary location and mini-labs at two satellite locations
- Standardized protocols and eliminated non-value added steps
- Eliminated non-profitable tests
- Implemented “No Dx, no test” rule
- Right-sized appropriate skill set to activity
- Replaced overcompensated FTEs with “rightly” compensated FTEs
- Reduced staff by 1.95 FTEs

Imaging (CT) Profitability Improvement

- Renegotiated maintenance contracts, lease, staff and contrast supply expenses
- Increased CT utilization by 12% through measuring number of tests referred out
- Trained staff and physicians to use internal service

Decreased Rent Expense per MD

- Benchmarked square footage to MGMA/MD FTE Percentile
 - 25% median, 75% or 90% for service line
- Determined and identified excess space per MD utilization per location
- Redesigned workflow to “right size” to MD utilization
- Leased out excess square footage to local hospitals
- Decreased overhead

Physician Best Practice Model Outcomes

- \$3.8 million saved in expenses!
- Increased physician compensation
- Increased lab and imaging profitability
- Improved morale

Note: Organization has sustained improvement gains. They continue to benchmark and raise the bar with ongoing waste reduction efforts!

Teamwork! The Key to Success



Thank you!

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